State of Rhode Island
Department of Health
Board of Medical Licensure & Discipline

IN THE MATTER OF:
James Gloor, MD
License No.: MD 05692
Case No.: C191193 and C201370

CONSENT ORDER

James Gloor, MD ("Respondent") is licensed as a physician in Rhode Island. The Board of Medical Licensure and Discipline ("Board") makes the following

FINDINGS OF FACT

1. Respondent graduated from West Virginia School of Medicine on June 1, 1979, and has been licensed as a physician in the State of Rhode Island since July 1,1980. At that time, Rhode Island required only one year of residency to obtain licensure, which Respondent had. Respondent's primary specialty is general practice. His practice is located at 7260 Post Road, North Kingstown, Rhode Island. He is not board certified and holds no hospital privileges. Pursuant to a Consent Order signed by Respondent and ratified by the Board on January 11, 2017, the Respondent received a reprimand from the Board for failure of his medical records to meet the regulatory requirements, lacking in legibility and necessary content.

2. The Board received complaint 191193 regarding Respondent's care of Patient A (alias), for whom Respondent was the attending physician.

3. The complaint was wide ranging—it involved treatment of a patient dating back as far as

2013—and primarily secondhand.

4. Ultimately, pursuant to its review of the complaint, Respondent's representations to the Board, including his written response, and Respondent's medical records, the Investigative Committee found Dr. Gloor's documentation of treatment to be lacking, which called his treatment of Patient A—and others--into question, particularly with respect to whether Respondent's treatment satisfied the standard of care.

5. According to the complaint, Respondent, for years, prescribed Patient A excessive anxiety and sleeping medications, in excessive doses, without psychiatric consultation or treatment. According to the complaint, Patient A had previously overdosed on these medications in 2013 and 2017, for which Patient A was hospitalized and subsequently received follow-up psychiatric treatment at Butler Hospital. Additionally, the complaint states that Respondent evaluated Patient A after Patient A fell in her home, which resulted in swelling and some bleeding on her head. In his written response to the Board, Respondent stated that he saw Patient A on September 10, 2019—nine days after Patient A's fall. He admitted that he prescribed Patient A Valium, 5mg, #20, because he was concerned about paracervical spasm. Respondent also acknowledged that Patient A had a history of alcohol abuse in his response.

6. The Investigative Committee reviewed Respondent's medical record for Patient A.

7. At the outset, the Investigative Committee noted that Respondent's documentation of Patient A's September 10, 2019 visit is confined to one sheet of paper and contains no documentation of paracervical spasm.

8. Respondent's documentation of Patient A's history of present illness is scant. There is no documentation relative to Respondent prescribing Patient A an antidepressant during the September 10, 2019 visit, or even addressing Patient A's depression. There is no documentation

to explain how or why Patient A fell, nor is there an assessment of whether Patient A suffered additional injuries in the fall. Further, it is unclear from Patient A's medical record why she was prescribed Valium—a benzodiazepine—at this visit, for she was already prescribed Klonopin—also a benzodiazepine—which was last filled on September 7, 2019, three days earlier, and had been prescribed Restoril—another benzodiazepine—which was last filled on June 6, 2019, as well as Xanax—yet another benzodiazepine—which was last filled on April 2, 2019. These four prescribed benzodiazepines do not overlap, but it is unclear from the medical record why Patient A was prescribed four different benzodiazepines over such a short span of time, i.e., five months. Pursuant to its investigation, the Investigative Committee also noted several significant deficiencies relative to Respondent's meeting the minimum standard of care. For example, the Investigative Committee noted that Respondent evaluated Patient A for increased depression and anxiety on June 18, 2012, yet the medical record contains no meaningful history, physical exam, social history, review of systems, or medical decision making for that date. There is no documented assessment of self-harm.

9. Further, on May 17, 2013, Respondent diagnosed Patient A with "ETOH withdrawal" and prescribed "Antabuse 250 RF x2." The medical record contains inadequate documentation of history of present illness, review of systems, physical exam, assessment, and plan. There is no assessment of risk of self-harm. There is no discussion of alcohol or drug use. Pursuant to its review of Patient A's medical record, the Investigative Committee requested that Respondent provide it with ten additional sets of medical records, to be chosen by Respondent, limited in scope to just the preceding 12 months. Respondent provided the Investigative Committee with the requested medical records for Patients A-J (alias), for whom Respondent was the attending physician.

10. Pursuant to its review of Respondent's medical record for Patient B, the Investigative Committee identified several deficiencies in the quality of care afforded Patient B and in the medical record, itself. For example, the medical record reflects that, on multiple occasions, Respondent prescribed Patient B an antibiotic for a viral illness. Also, the medical record reflects that when, at times, Patient B presented with respiratory symptoms, such as cough, Respondent did not perform a lung exam.

11. Pursuant to its review of Respondent's medical record for Patient C, the Investigative Committee identified several deficiencies in the quality of care afforded Patient C and in the medical record, itself. For example, the medical record reflects that Respondent prescribed Patient C an antibiotic and a narcotic cough syrup—Phenergan with codeine—for a viral illness. Overall, the Investigative Committee concluded that Respondent's care of Patient C and documentation thereof failed to meet the standard of care.

12. Pursuant to its review of Respondent's medical record for Patient E, who was evaluated for vertigo by Respondent on February 5, 2019, the Investigative Committee identified several deficiencies in the quality of care afforded Patient E and in the medical record, itself. For example, the Investigative Committee noted of the medical record that documentation of the physical exam referenced only tympanic membranes and a clear pharynx. On that date, Respondent nevertheless diagnosed Patient E with vertigo and prescribed Antivert, Astelin, and Flonase. On February 7, 2019, Respondent re-evaluated Patient E for a recheck of vertigo. In the history of present illness for that date, Respondent noted that Patient E had previously been diagnosed with "B" cell lymphoma and did not wish to pursue chemotherapy. The medical record includes diagnostic lab studies, dated February 5, 2019, relative to that diagnosis, which studies reveal that Patient E was in severe renal failure, and suffering from significant anemia

and electrolyte abnormalities. Nevertheless, it appears from the medical record that, for unknown reasons, this information was not conveyed to Patient E until the February 7, 2019 visit. When Respondent saw Patient E on February 7, 2019, he told her to go to Rhode Island Hospital Emergency Department. The Investigative Committee determined that Patient E was not examined adequately at either visit, there was an inadequate assessment, and the patient was not notified of significantly abnormal lab results with serious diagnosis in a timely manner. Overall, the Investigative Committee concluded that Respondent's care of Patient E and documentation thereof failed to meet the standard of care.

13. Pursuant to its review of Respondent's medical record for Patient F, who was evaluated by Respondent on June 1, 2019 for itchy, red rash on the left side of the face and down the neck, the Investigative Committee identified several deficiencies in the quality of care afforded Patient F and in the medical record, itself. For example, the Investigative Committee noted of the medical record that the physical exam was minimal, consisting solely of "Bilateral red cheeks." The history of present illness was minimal and did not justify the course of treatment. Patient F was prescribed a narcotic cough syrup—Phenergan with codeine—for which medication there was no clear indication documented in the medical record. Overall, the Investigative Committee concluded that Respondent's care of Patient F and documentation thereof failed to meet the standard of care.

14. Pursuant to its review of Respondent's medical record for Patient H, who was evaluated by Respondent on several occasions, the Investigative Committee identified several deficiencies in the quality of care afforded Patient H and in the medical record, itself. For example, the Investigative Committee noted that Respondent evaluated Patient H for an annual physical on October 11, 2019, which exam the Investigative Committee determined to be inadequate, as,

according to the medical record, it included only a cursory exam of the abdomen, heart, chest and knee. At the time, Patient H was taking Temazepam—a benzodiazepine—and Tramadol—an opioid, notwithstanding the fact that the medical record contains no documentation as to why Patient H was prescribed this combination of medications. Nor is there documentation of Patient H having been educated about the risk associated with combining these two drug types, for which the FDA has required a so-called "black box warning" on the drug packaging. Patient H was subsequently evaluated on October 24, 2019, for follow up of high blood pressure. His blood pressure was elevated at this visit—136/94—and there was no plan for treatment or for follow up relative to Patient H's hypertension. That day, Patient H reported back pain. The Investigative Committee concluded that, according to the medical record, Respondent's examination of Patient H's back was inadequate, for there was no assessment of range of motion, no assessment of gait, no assessment of spine other than lumbar-sacral, and no neurological exam. Also, there was no cardiac exam, which in the context of hypertension is required to meet the minimum standard of care. Overall, the Investigative Committee concluded that Respondent's care of Patient G and documentation thereof failed to meet the standard of care.

15. The Investigative Committee, after reviewing Respondent's care of Patients A-H, and the associated medical records, concluded that, globally, Respondent's medical records fail to provide sufficient evidence of medical decision-making, differential diagnosis, and meaningful histories. Absent from the medical records for Patients C, D, F, and G, who were prescribed Phenergan with codeine or Robitussin with codeine, both of which are opioids, is any documentation that they were educated about the risks associated with taking opioids, such as dependence and addiction, and the risks associated with co-ingestion of opioids with alcohol or other psychoactive medications. Absent, as well, is documentation of education relative to safe

storage and other requirements set forth in the above-referenced regulation.

16. With respect to Patients C, D, and G, who were prescribed Phenergan with codeine, Respondent did not review the PDMP for these patients prior to prescribing the medication.

17. On September 17, 2020, the Board was emergently notified by the Rhode Island Medical Society Physician Health Program ("PHP") that Respondent had recently become noncompliant with the substance use disorder monitoring contract he had entered into with the PHP in January of 2017. Pursuant to the notification, the Board opened complaint 201370.

18. Pursuant to the complaint, Respondent voluntarily surrendered his license by consent order on September 22, 2020.

19. Respondent cooperated with the PHP, obtained necessary treatment, and made substantial process. He is considered in recovery.

20. Respondent violated R.I. Gen. Laws § 5-37-5.1(5), (19), and (24), which define "unprofessional conduct" as including, respectively, in relevant part, "*[d]ependence upon controlled substances,*" and "*any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board;*" and "*[v]iolating any provision or provisions of this chapter or the rules and regulations of the board or any rules or regulations promulgated by the director or of an action, stipulation, or agreement of the board;*" and Section 1.5.12(D) of the Rules and Regulations for the Licensure and Discipline of Physicians (216-RICR-40-05-1), on "Medical Records," and Sections 4.4(D) and 4.4(E) of the Rules and Regulations for Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances in Rhode Island (216-RICR-20-20-4), on "Patient Education / Informed Consent" and "Mandatory PDMP Review," respectively.

Based on the foregoing, the parties agree as follows:

1. Respondent admits to and agrees to remain under the jurisdiction of the Board.

2. Respondent has agreed to this Consent Order and understands that it is subject to final approval of the Board and is not binding on Respondent until final ratification by the Board.

3. If ratified by the Board, Respondent hereby acknowledges and waives:

a. The right to appear personally or by counsel or both before the Board;

b. The right to produce witnesses and evidence on his behalf at a hearing;

c. The right to cross examine witnesses;

d. The right to have subpoenas issued by the Board;

e. The right to further procedural steps except for those specifically contained herein;

f. Any and all rights of appeal of this Consent Order;

g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review; and

h. Any objection that this Consent Order will be reported to the National Practitioner Data Bank and Federation of State Medical Boards and posted to the Rhode Island Department of Health ("RIDOH") public website.

4. Respondent agrees to pay, within 12 months of the ratification of this Consent Order, an administrative fee of $4,905.00 for costs associated with investigating the above-referenced complaint. Such payment shall be made by certified check, made payable to "Rhode Island General Treasurer," and sent to Rhode Island Department of Health, 3 Capitol Hill, Room 205, Providence, RI 02908, Attn: Lauren Lasso. Respondent will send notice of compliance with this condition to DOH.PRCompliance@health.ri.gov within 15 days of submitting payment.

5. Respondent agrees to this reprimand on his physician license.

6. Respondent's license is suspended for three years from ratification of this Consent Order, less the period of Respondent's voluntary surrender of his physician license, from September 22, 2020 to the ratification of this Consent Order. The suspension is immediately stayed for so long as Respondent adheres to the conditions of this Consent Order. Respondent's license is reinstated from voluntary surrender upon ratification of this Consent Order, and the September 22, 2020 Voluntary Surrender shall automatically terminate.

7. Respondent shall, at his own expense, within 8 months of the ratification of this Consent Order, attend (in person or virtually) and be assessed by the Center for Personalized Education for Physicians (CPEP) or Lifeguard Assessments for evaluation of Respondent's clinical competency. Respondent shall follow all recommendation of the assessor, which recommendations shall be incorporated by reference within this Consent Order. Notwithstanding the foregoing, Respondent retains the right to contest the inclusion of any such recommendations. All results shall be forwarded directly to the Board at DOH.PRCompliance@health.ri.gov as soon as possible after a final report is completed by CPEP or Lifeguard.

8. Respondent shall remain under contract with the PHP for a minimum of 5 years from the date of most recent execution and shall abide by the terms and conditions set forth therein. Respondent must also follow the instructions and recommendations of the PHP during the period of the contract.

9. In the event that Respondent violates any term of this Consent Order after it is signed and accepted, the Director shall have the discretion to impose further disciplinary action, including immediate suspension of Respondent's medical license. If the Director imposes further disciplinary action, Respondent shall be given notice and shall have the right to request an

administrative hearing within 20 days of the suspension and/or further discipline. The Director shall also have the discretion to request an administrative hearing after notice to Respondent of a violation of any term of this Consent Order. The Board may suspend Respondent's license, or impose further discipline, for the remainder of Respondent's licensing period if the alleged violation is proven by a preponderance of evidence.

Signed this 12th day of April, 2021.

James Gloor, MD

Ratified by the Board of Medical Licensure and Discipline on the 14th day of April 2021.

Nicole Alexander-Scott, MD, MPH
Director
Rhode Island Department of Health
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Providence, RI 02908